

## Abstract

The Arizona MAT-PDOA Criminal Justice Project is a collaborative initiative between the Arizona Health Care Cost Containment System (AHCCCS) and the Regional Behavioral Health Authorities in Arizona to address the need for medication assisted treatment (MAT) to treat opioid use disorder (OUD) for individuals involved with the criminal justice system. The project will create a bridge between incarceration and outpatient treatment. Outcomes will include an increase in individuals enrolled in MAT and integrated care services, a reduction in illicit opioid use, a reduction in the use of prescription opioids in a non-prescribed manner, and re-incarceration of individuals receiving services through this project. The project also seeks to reduce the stigma associated with MAT for individuals involved in the criminal justice system. The project will serve individuals who have been diagnosed with OUD and have been screened for MAT-eligibility. These individuals must be participating in drug courts, probation, parole, and/or be within 4 months of release from various detention facilities in Maricopa or Pima Counties. Individuals who are MAT-eligible are of lower socio-economic status compared to the general population (with average incomes ranging from \$175 to \$635.76 per month), predominantly white, and in Maricopa County the majority identified as men (45.8%), with women representing the second largest gender identify (41.1%), and questioning, gender variant, intersex, or transgender combined comprising 8.5%. In Pima County 54.6% of MAT-eligible individuals identified as men, 42.4% identified as women, and 0.1% identified as questioning, gender variant, intersex, or transgender. There will be both provider and system-level education and training on the nature, application and implementation of MAT services in order to reduce stigma and promote MAT. The project goals include improving access to MAT-services for target population by improving infrastructure and collaboration among criminal justice entities and OTPs. The project will expand infrastructure and build capacity for state, regional, and local collaborators to implement integrated behavioral health, care coordination, and recovery support team approaches and integrated strength-based treatment planning, screening and assessment for co-occurring disorders for the target population by increasing participation in MAT services. Project will increase knowledge and skill levels of clinical staff by providing training in aforementioned implementation initiatives in addition to Moral Reconnection Therapy. In addition to individual counseling services provided through the OTPs, the providers will implement Moral Reconnection Therapy (MRT) programs. Participant outcomes will include an increase in participant abstinence from illicit and non-illicit opioid use, decrease percentage of recidivism in criminal justice involvement, and decrease tobacco use. The Project will serve a total of 80 unduplicated individuals annually and a total of 240 over the 3 year program period.

Abstract	1
Table of Contents	2
Budget Information Form	Not numbered
Section A: Population of Focus and Statement of Need	3
Section B: Proposed Evidence-Based Service/Practice	8
Section C: Proposed Implementation Approach	11
Section D: Staff and Organizational Experience	25
Section E: Data Collection and Performance Measurement	29
Section F: States Identified in Section V	32
Other Attachment File 1:	
Section G: Biographical Sketches and Job Descriptions of Key Staff	
Section H: Confidentiality and SAMHSA Participant Protection/Human Subjects	
Other Attachment File 2:	
Attachment 1: Identification of Direct Service Provider Organizations Participating in the Project & Letters of Commitment	
Attachment 2: Data Collection Instruments/Interview Protocols	
Attachment 3: Sample Consent Forms	
Attachment 4: Electronic Health Record	
Attachment 5: Rate of Change of Primary Admission for Heroin and Non-Heroin Opiates between 2007-2013	
Attachment 6: Data Tables	

## **Section A: Population of Focus and Statement of Need (15 points)**

**A1:** Opiate use is an increasing problem in Arizona, with drug-related inpatient discharges and emergency room visits involving opiates increasing Statewide from 8,013 in 2004 to 23,093 in 2013. The Arizona Health Care Cost Containment System (AHCCCS) has identified Maricopa and Pima counties as initial implementation communities for this grant. According to the Arizona Department of Health Services Population Health and Vital Statistics, in 2013, Maricopa County's rate of Opiates/Opioids contributing to death was 5 per 100,000 and in Pima County the rate was 14.9 per 100,000<sup>1</sup>. Since 2010, the number of overdose deaths in Pima County has risen by nearly 20 percent. Among overdose deaths, the majority of cases were caused by opiate drugs<sup>2</sup>. Comparable information was not made available by the Maricopa County Medical Examiners office, but Opium use morbidity rates in 2013 for Pima County and Maricopa County were among the highest compared to other counties (362.1 per 100,000 and 200.3 per 100,000, respectively)<sup>3</sup>. Further, according to United States census data, the percent of individuals without health insurance, under age 65 years is 16%, whereas both Pima and Maricopa Counties have a larger percentage of individuals without health insurance (18.8% and 19.8%, respectively)<sup>4</sup>.

Arizona Department of Health Services Population Health and Vital Statistics found that statewide, there were 476,076 injury and poisoning-related inpatient discharges and emergency room visits. Maricopa County and Pima County accounted for 70.9% and 12.2% of the state's injury and poison-related inpatient discharges, respectively<sup>5</sup>.

According to the Arizona Department of Health Services Population Health and Vital Statistics, in 2013, Maricopa County's rate of Opiates/Opioids contributing to death was 5 per 100,000 and in Pima County the mortality rate was 14.9 per 100,000<sup>6</sup>

In Arizona's HIV/AIDS reporting, estimates of incidence are based upon the sum of new HIV cases, and new AIDS cases not diagnosed as HIV infections in any prior calendar year. These cases are referred to as emergent cases and are used as an estimate of incidence. Cases of HIV/AIDS can only be counted as emergent in the year they were first diagnosed with HIV infection. Persons who were emergent as HIV and diagnosed as AIDS in the same calendar year are counted as emergent AIDS to avoid double counting. This method is the most straightforward method available for estimating incidence. Prevalence, on the other hand, refers to the total summation of infected and alive cases present in the state at the end of the year. In 2014, the Maricopa County prevalence of HIV/AIDS was 11,557 and incidence was 569<sup>7</sup>. Pima

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<sup>1</sup> Arizona Department of Health Services (ADHS) Inpatient discharges and emergency room visits related to opiates by age group, gender, and county of residence (Table A5) 2013 and 2004 <http://azdhs.gov/plan/hip/index.php?pg=drugs>

<sup>2</sup> Pima County Office of the Medical Examiner Annual Report 2014

[https://webcms.pima.gov/UserFiles/Servers/Server\\_6/File/Government/Medical%20Examiner/Resources/Annual-Report-2014.pdf](https://webcms.pima.gov/UserFiles/Servers/Server_6/File/Government/Medical%20Examiner/Resources/Annual-Report-2014.pdf)

<sup>3</sup> ADHS Community Profiles Dashboard <http://www.azdhs.gov/preparedness/public-health-statistics/profiles/>

<sup>4</sup> United States Census QuickFacts <http://www.census.gov/quickfacts/>

<sup>5</sup> ADHS Population Health and Vital Statistics Tables B and C <http://www.azdhs.gov/plan/hip/index.php?pg=injury>

<sup>6</sup> Pima County Community Health Needs Assessment 2015

[https://webcms.pima.gov/UserFiles/Servers/Server\\_6/File/Health/Resources%20for%20Professionals/Health%20Data,%20Statistics%20and%20Reports/Pima%20CHNA-FNL-web.pdf](https://webcms.pima.gov/UserFiles/Servers/Server_6/File/Health/Resources%20for%20Professionals/Health%20Data,%20Statistics%20and%20Reports/Pima%20CHNA-FNL-web.pdf)

<sup>7</sup> ADHS HIV Epidemiology Report 2014 Central Region <http://www.azdhs.gov/phs/edc/odis/documents/hiv-epidemiology/2014/hiv-central-region.pdf>

County's 2014 prevalence was 2,607 and incidence was 96<sup>8</sup>. According to ADHS' preliminary analysis of electronic lab reporting shows 11,611 newly reported cases of Hepatitis C in 2013.

Meta-analyses have demonstrated that when jails and prisons provide Cognitive Behavioral Programming, recidivism and relapse rates can decrease from 66% to 33% within the first year of release<sup>9</sup>. This proves to be more difficult when discussing opioid dependent individuals that received no treatment as approximately 95% of incarcerated opioid users return to use within 3 years of being released from custody<sup>10</sup>. Research has found that when Medication Assisted Treatment (MAT) is implemented, 55.9% of those individuals do not relapse or recidivate<sup>11</sup>. Major problems for reentry persist when the incarcerated person is being released without a proper transition to the community. A study conducted in San Francisco found that 42% of persons with medical needs in conjunction with substance use disorders that had regular access to care still reported significant interruptions in care when transitioning between jail and the community<sup>12</sup>. AHCCCS believes that by designing a program targeting the pre-release incarcerated population in Maricopa and Pima Counties and offering a program that bridges incarceration to outpatient treatment, the number of individuals that follow through with treatment will increase. Additionally, based on the evidence, it is logical that Arizona will see improved outcomes, including reduction in recidivism, decreased incidence of overdose, and increased collaboration among criminal justice entities and behavioral health providers with this MAT programming.

For the purposes of the grant, Arizona will focus on individuals with Opioid Use Disorders involved with the Criminal Justice System, specifically focusing on outreaching and screening individuals within four months of release to engage them in treatment and provide care coordination as they reenter the community. This outreach while incarcerated will allow for the MAT providers to screen and engage eligible individuals prior to release in order to create a bridge between treatment while incarcerated to outpatient treatment. AHCCCS believe that ensuring a seamless transition upon reentry will increase eligible individuals admitted into MAT programs, an increase in the number of individuals receiving integrated treatment, a decrease in illicit opioid drug use, and a decrease in the use of prescription opioids in a non-prescribed manner.

Statewide in the public behavioral health system members with a substance use disorder (SUD) diagnosis have more involvement with the criminal justice system than members without a SUD. In Pima County the percentage of members on parole for the SUD population is three times the percent of members who do not have an SUD. In Maricopa County the percent of members on parole for the SUD population is more than double the percent of members who do not have an

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<sup>8</sup> ADHS HIV Epidemiology Report 2014 Southern Region <http://www.azdhs.gov/phs/edc/odis/documents/hiv-epidemiology/2014/hiv-southern-region.pdf>

<sup>9</sup> Landenberger, N. A., & Lipsey, M. W. (2005). The positive effects of cognitive-behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology*, 1(4), 451-476

<sup>10</sup> Marlowe, D. B. (2003). Integrating substance abuse treatment and criminal justice supervision. *Science & Practice Perspectives*, 2(1), 4-14

<sup>11</sup> Clark, C. B., Hendricks, P. S., Lane, P. S., Trent, L., & Cropsey, K. L. (2014). Methadone maintenance treatment may improve completion rates and delay opioid relapse for opioid dependent individuals under community corrections supervision. *Addictive behaviors*, 39(12), 1736-1740

<sup>12</sup> Wang, E. A., White, M. C., Jamison, R., Goldenson, J., Estes, M., & Tulskey, J. P. (2008). Discharge planning and continuity of health care: findings from the San Francisco County Jail. *American Journal of Public Health*, 98(12), 2182-2184

SUD. The percent of SUD population in Pima County on probation is more than five times the percent of members who do not have an SUD and in Maricopa County the percent of members with SUD on is almost six times the percent of members who do not have an SUD. Finally, the percent of members with SUD in Pima County that were arrested during treatment is more than 2.5 times the percent of members who do not have an SUD and in Maricopa County the percent of members with SUD that who were arrested during treatment is more than six times the percent of members who do not have an SUD (see Attachment 6, Table 12 for full details).

Through the outcomes of this program AHCCCS plans to release program results to assist the remaining 13 counties across the state in forming partnerships between providers and the criminal justice system to show efficacy of MAT, reduction in recidivism, and reduce stigma of MAT in the criminal justice system. While there are numerous policies which direct service provision, the area of MAT has been driven primarily by state and federal licensure requirements. Currently all three Regional Behavioral Health Authorities (RBHAs) offer integrated physical and behavioral health care for the Seriously Mentally Ill population.

**A2:** According to the 2014 United States Census Bureau Arizona's estimated population is 6,731,484<sup>13</sup>. Arizona ranked sixth highest in the nation in 2010 for drug overdose deaths and had the fifth highest opioid prescribing rate in the U.S. in 2011<sup>14</sup>. Currently there are a total of 13 SAMHSA-approved Opioid Treatment Programs (OTPs) contracted with Mercy Maricopa Integrated Care (MMIC), the Regional Behavioral Health Authority (RBHA) for Maricopa County, providing MAT services to individuals enrolled receiving behavioral health services funded through either Medicaid or Substance Abuse Prevention and Treatment Block Grant. In Pima County there are 5 SAMHSA-approved OTPs contracted with the RBHA overseeing Pima County.

Although the Affordable Care Act requires many insurers to cover addiction treatment benefits, many policies impose prior authorizations requirements, place limits on medication dosage and length of treatment, or require individuals to “fail first” at non-medication treatment options for one or even all medications. Many OTPs have shared the difficulties their clients have with their private insurance plans covering MAT. Many report their plans do not cover Methadone because it is considered maintenance and not a treatment medication. These restrictions force individuals to either pay out of pocket, up to \$300 per week, or forgo crucial treatment all together.

Although training on MAT has been available throughout the state, many criminal justice entities and professionals continue to have limited understanding of MAT available for opioid dependence and little or no connection to the OTPs in the community. Some current MAT providers have shared numerous experiences with criminal justice entities that disapprove of MAT and require an individual to be “drug-free” to be compliant with terms of their probation, parole, or other court orders. Because criminal justice professionals make treatment referrals and monitor a client's progress in treatment, the lack of knowledge about and support for MAT (as a viable evidence-based treatment for opioid dependence) becomes a barrier to participation in MAT and a risk to the MAT-eligible individuals.

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<sup>13</sup> US Census QuickFacts <http://quickfacts.census.gov/qfd/states/04000.html>

<sup>14</sup> ADHS website for clinicians: <http://azdhs.gov/clinicians/index.htm>

**A3:** During Federal Fiscal Year 2015, there were 9,744 individuals enrolled statewide in the state's public behavioral health system who were MAT-eligible. MAT-eligible is defined by individuals during Federal Fiscal Year 2015 with an Opioid Use Disorder as an Axis I diagnosis that received behavioral health services funded through Medicaid, Federal Block Grants (SABG/MHBG), Federal Discretionary Grants, or State funds. Of those 9,744 MAT-eligible individuals, 77.7% resided in Maricopa and Pima counties (50.4% in Maricopa, and 27.3% in Pima). Heroin/Morphine (62.0%) was identified as the primary opioid substance utilized across the state. Maricopa and Pima Counties were among the highest percent with 61.3% of members in Maricopa County and 69.3% of members in Pima County indicating heroin/morphine as the primary opioid substance used. In Pima and Maricopa counties, members indicated a similar percent of other opiates used that were not heroin or morphine (31.3% and 31.1%, respectively).

MAT-eligible individuals in Maricopa County identified as white (89.0%), 1.4% identified as American Indian, 5.1% as African American, and 4.2% identified as Native Hawaiian, Asian, or multiracial. Similar rates were reported in Pima County: 93.6% of the MAT-eligible individuals identified as white, 1.4% as American Indian, 3.3% as African American, and 1.5% as Native Hawaiian, Asian, or multiracial. Statewide, 24.2% of MAT-eligible individuals identified as Hispanic or Latino. Of the MAT-eligible individuals, 20.0% identified as Hispanic or Latino in Maricopa County, while 36.2% identified as Hispanic or Latino in Pima County.

MAT-eligible individuals in Maricopa County identified their gender as men (45.8%), as women (41.1%), and as questioning, gender variant, intersex, or transgender (8.5%). Pima County differed slightly; 54.6% of MAT-eligible individuals identified as men, 42.4% identified as women, and 0.1% identified as questioning, gender variant, intersex, or transgender.

Regarding sexual orientation, 83.9% of the individuals identified as heterosexual, 5.8% as gay or lesbian, and 5.8% as asexual, questioning, or bisexual in Maricopa County. In Pima County, MAT-eligible individuals identified as heterosexual (89.4%), as gay or lesbian (2.1%), or as asexual, questioning, or bisexual (2.4%).

Over half (53.4%) of the 8,329 enrolled members statewide were between the ages of 18 and 34. For Maricopa County, about half (50.3%) of the individuals were between the ages of 18 and 34. Nearly 60% of the individuals in Pima County were between the ages of 18 and 34.

In Maricopa County, 3.7% of MAT-eligible individuals were pregnant, while in Pima County 2.7% were pregnant.

In Maricopa County the average household size was one family member. The average household monthly income for a single-person household was \$175 and \$635 for a family household. In Pima County, the same average household size was reported (one), with an average household monthly income of \$240 for a single-person household and \$538 for a family household. All demographic data referenced in this section was collected from enrolled member data. For full demographic details see tables 2-11 in Attachment 6.

**A4:** Comparing race and ethnicity of those individuals with opioid use disorder seeking or receiving treatment with U.S. census data in Pima and Maricopa Counties, the percent of MAT-eligible individuals in the behavioral health system is lower for minority populations. According to U.S. census data, 4.3% and 2.8% of the general population in Pima and Maricopa counties, respectively, are American Indian. However, for MAT-eligible individuals these percentages were lower (1.4% in both Pima and Maricopa counties). One reason for this could be that American Indian individuals eligible for services through the public behavioral health system in Arizona have the options to receive behavioral health services through the RBHA in their area or through their tribe or Indian Health Services. AHCCCS is aware of this disparity and will evaluate program to ensure focused outreach on the American Indian population in the identified communities. The percent of African Americans in the general populations of Pima (4.1%) and Maricopa (5.7%) counties were similar to the percent of MAT-eligible (3.3% in Pima and 5.1% in Maricopa); however these percent were still lower. The Native Hawaiian, Asian, and multiracial populations have a collective percent of the general population in Pima County (6.1%) and Maricopa County (7.2%). The percent of MAT-eligible individuals (from these same racial groups) in Pima County and in Maricopa County were 1.5% and 4.2%, respectively. The percent of white MAT-eligible individuals was higher in Pima (93.6%) and Maricopa (89.0%) counties, compared to the general populations in Pima County (85.5%) and Maricopa County (84.4%). The general population and the MAT-eligible population had a similar percentage of Hispanic individuals (36.1% and 36.2%, respectively). In Maricopa County, 30.3% of the general population are Hispanic individuals compared to 20.0% of the MAT-eligible population. The percent of women eligible for MAT (42.4% in Pima County and 41.1% in Maricopa County) was lower compared to the general populations in Pima and Maricopa counties (50.8% and 50.6%, respectively).

According to the U.S. census data, the median annual household income is \$46,233 in Pima County and \$53,689 in Maricopa County<sup>15</sup>. Among enrolled MAT-eligible individuals, the estimated annual income\* is \$4,941 and \$2,330 in Pima and Maricopa counties, respectively. The estimated annual income is based on the monthly income reported in the members' behavioral health demographic assessments.

At present, additional subpopulation disparities in access, utilization and outcome reporting are unknown. AHCCCS plans to leverage the Health Disparities Statement deployed 60 days into program implementation to identify and mitigate risk to barriers in accessing MAT services.

**A5:** AHCCCS intends to use funds for infrastructure or workforce development to support training, education and outreach to health care providers and individuals working in the criminal justice system. AHCCCS will organize both provider and system-level education and training on the nature, application and implementation of MAT services. Additionally AHCCCS will arrange training regarding the efficacy of MAT be provided to criminal justice personnel which will result in increased identification and implementation of best practices for providing and referring criminal justice-involved individuals with opioid use disorders appropriate evidence-based substance use treatment, including MAT.

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<sup>15</sup> United States Census <http://www.census.gov/quickfacts/>

**Section B: Proposed Evidence-Based Service/Practice (20 points)**

**B1:** The overarching goal of the project is to increase access to Medication Assisted Treatment (MAT), coordinated and integrated care, and recovery support services for individuals involved in the criminal justice system identified as MAT eligible to reduce drug overdose, opioid addiction, and re-incarceration due to drug use. The project approach includes developing and supporting state, regional, and local level collaborations and services enhancements to develop and implement best practices to comprehensively serving MAT eligible individuals participating in drug courts, probation, parole, and/or who are within 4 months of release from various detention facilities.

**Goal 1: Improve access to comprehensive MAT services for 80 unduplicated MAT eligible individuals per year participating in drug courts, probation, parole, and/or who are within 4 months of release from various detention facilities in Maricopa and Pima Counties.**

**Objective 1.1:** By November 30, 2016, increase infrastructure and access by identifying and contracting with MAT providers, in Maricopa and Pima County working with criminal justice involved MAT eligible clients, to provide comprehensive and integrated MAT services as measured by signed contracts.

**Objective 1.2:** By September 29, 2019, increase identification of MAT eligible individuals involved in the criminal justice system by outreaching and screening the target population for eligibility in Maricopa and Pima Counties, as measured by the number of completed eligibility screenings conducted annually.

**Objective 1.3:** By September 29, 2017 (and annually to 9/29/19), increase access to services by enrolling at least 80 unduplicated MAT eligible individuals per year, who are involved in the Maricopa and Pima County criminal justice systems, enrolled with the contracted Medication Assisted Treatment providers, and receiving comprehensive MAT services as measured by the number of individuals enrolled and receiving services.

**Goal 2: Expand infrastructure and build capacity for state, regional, and local collaborators to implement integrated behavioral health, care coordination, and recovery support team approach and integrated strength based treatment planning, screening and assessment for co-occurring disorders for the target population.**

**Objective 2.1:** By December 30, 2016, increase knowledge and skill levels of new and existing clinical staff by providing training workshops in integrated behavioral health, care coordination, and recovery support team approach, integrated strength based treatment planning, screening and assessment for co-occurring disorders, and Moral Reconciliation Therapy as measured by pre/post training surveys. Additional actual practice surveys will be conducted at 6- and 12-months post training to determine training effectiveness.

**Objective 2.2:** By September 29, 2019, increase participation in and access to MAT services, addressing the specific needs of target population as measured by number of outreaches, percentage of admissions from outreach, and percentage of subsequent treatment plans implemented.



**Objective 2.3:** By September 29, 2019, increase client abstinence from illicit and non-illicit opioid use at 6-month post enrollment by 80% as measured by drug test conducted by provider at prescribed 6-month interval.

**Objective 2.4:** By September 29, 2019, decrease percentage of recidivism among enrolled clients as measured by 65% reduction in revoked probation and parole leading to incarceration.

**Objective 2.5:** By September 29, 2019, decrease percentage of enrolled participants who used tobacco in the past 30-days by 50% as measured by past 30-day tobacco measure indicated at intake, 6 months, and 12 months.

**Goal 3: Enhance state, regional, and local integrated care and criminal justice partnerships to build capacity to sustain and /or expand best practices to providing comprehensive MAT services to individuals involved in the criminal justice system.**

**Objective 3.1:** By September 29, 2019, increase collaboration, coordination, and partnerships at the state, regional, and local level by 60% between the integrated care system, recovery support services, and criminal justice system by implementing an Arizona MAT-PDOA Criminal Justice Project as measured by the Wilder Collaboration Factors Inventory.

**Objective 3.2:** By September 29, 2019, increase knowledge and capacity and reduce stigma related to MAT services by developing and providing education materials and training workshops to Arizona MAT-PDOA Criminal Justice Project stakeholders as measured by retrospective pre surveys and 6-month follow-up surveys with participants.

**Objective 3.3:** By September 29, 2019, increase capacity for replication by criminal justice systems and MAT providers across Arizona by identifying and disseminating program impacts and outcomes as measured by the number of products/presentations developed and disseminated annually.

**B2:** AHCCCS requires all contractors and providers to follow AHCCCS Policy and Contractor Manuals and adhere to medication guidelines detailed in policy. Medical staff will be expected to provide the most clinically appropriate medication for each individual ensuring each individual has a choice and voice in medication treatment. In order to minimize diversion for illicit purposes, providers will be expected to adhere to their agency's diversion prevention strategies, including medication callback protocols and random drug screening.

**B3:** The following are evidence-based practices (EBPs) that will be used for this project:

**Moral Reconciliation Therapy:** In addition to clinically appropriate evidence-based medication to treat Opioid Use Disorder and individual counseling services provided through the MAT Provider, the MAT provider will implement a Moral Reconciliation Therapy (MRT) program. Numerous studies have shown individuals participating in MRT programs have lower rates of recidivism than individuals not participating in MRT programs<sup>16</sup>. MRT is a cognitive-behavioral

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<sup>16</sup> SAMHSA's National Registry of Evidence-based Programs and Practices, Moral Reconciliation Therapy  
<http://legacy.nreppadmin.net/ViewIntervention.aspx?id=34>

based program that focuses on assisting participants in developing their abilities to make conscious decisions which lead to improved decision making and moral reasoning<sup>17</sup>. MRT has been used with individuals with criminal justice involvement since the 1980s and addresses individual's substance use as well as encourages conscious decision making. Criminal Justice entities in Arizona currently utilize the MRT program with incarcerated individuals. By offering this program in the outpatient provider setting it will offer individuals recently released from incarceration to have continuity in their treatment. In order to provide MRT to fidelity, the providers will be required to send clinical staff to MRT training. Each provider will be allowed to send two clinical staff members to formal MRT training which will be funded by this project. In the event that additional staff need to be trained, a request must be made to the Project Director to authorize payment for additional staff training.

**Motivational Interviewing:** Project staff will be required to show documentation of training in Motivational Interviewing (MI) within the past five years or participate in MI training within six months of project beginning. New employees hired on during the course of the project will be expected to provide documentation of MI training within the past five years or be trained within six months of hire date. MI is a semi directive, client-centered counseling style that elicits behavior change by helping clients explore and resolve ambivalence. It facilitates the development of the trusting relationship and the decision to make a change. Past research has supported that a brief motivational intervention delivered in a walk-in healthcare clinic by peer counselors was associated with improved abstinence rates and reductions in opioid and cocaine use<sup>18</sup>. Provider staff will use motivational interviewing techniques to build rapport and engage individuals beginning during outreach and continuing throughout course of treatment.

**The American Society of Addiction Medicine Criteria:** Project staff will utilize the ASAM Criteria 3<sup>rd</sup> edition dimensions and philosophy of assessment when assessing individuals enrolled in the project. The ASAM Criteria is an ongoing, multidimensional, person-centered, holistic treatment philosophy of care. The ASAM Criteria requires clinicians to effectively assess utilizing the criteria through assessment at individual's admission, service planning, treatment and discharge or transfer to higher or lower levels of care. Through utilizing the ASAM Criteria, provider staff will recognize the dimensional interaction and holistic treatment approach that is essential to effective integrated treatment. Under the ASAM Criteria an individual's care is delivered along a flexible continuum, tailored to the needs of the individual, and guided by a collaboratively developed treatment plan<sup>19</sup>. Utilizing The ASAM Criteria will allow individuals to feel engaged and that they have a voice in their treatment planning. Providers will utilize The ASAM Criteria at minimum at time of intake, six-month update, at discharge, and any time an individual has a significant life event that could effect their treatment.

**B3:** This section is not applicable due to the use of EBPs discussed above.

**B4:** We intend to use the above mentioned EBP's to reduce disparities as they have been proven to be effective according to controlled research studies for individuals who are involved with the criminal justice system and have a substance use disorder. Additionally, we will ensure that the

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<sup>17</sup> Moral Reconciliation Therapy <http://www.moral-reconciliation-therapy.com/aboutmrt.html>

<sup>18</sup> Bernstein, J., Bernstein, E., Tassiopoulos, K., Heeren, T., Levenson, S., & Hingson, R. (2005). Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence*, 77, 49-59.

<sup>19</sup> ASAM Criteria <http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria>

services are culturally competent delivered in an effective, understandable and respectful manner, compatible with service recipients' preferred language and cultural beliefs.

**B5:** AHCCCS understands the importance of implementing an evidenced-based program or practice as intended in order to maintain a high degree of fidelity. For this reason, the project does not intend to modify implementation of the evidenced-supported program in any significant way that could jeopardize the success of the project.

### **Section C: Proposed Implementation Approach (30 points)**

#### **C1:**

<b>Months post grant award</b>	<b>Key Activities/Milestones</b>	<b>Responsible Staff</b>
One	1. AHCCCS will finalize and provide funding allocation notification to MMIC and C-IC	Lesley Wimmer Kelly (Project Director)
	2. AHCCCS will finalize agreement with the Wellington	Lesley Wimmer Kelly
Two months post award	3. MMIC and C-IC will finalize contract with identified MAT Providers	MMIC/C-IC
	4. Initial Program Meeting to address: <ul style="list-style-type: none"> <li>- Prioritization of MAT regimens</li> <li>- Outreach and engagement strategies</li> <li>- Formalize plan for screening and assessing opioid use and MAT eligibility for potential project participants</li> <li>- Review/update protocols to prioritize treatment regimens less susceptible to diversion</li> <li>- Review/update protocols to mitigate the risk of diversion and ensure appropriate use/dose of medication.</li> <li>- Providing peer and other recovery support services</li> <li>- Develop approach/protocols for an integrated behavioral health, care coordination, integrated strength based treatment planning, screening and assessment for co-occurring disorders, and recovery support team approach.</li> <li>- Screening and assessment for co-occurring disorders</li> <li>- Review/update protocols of utilizing the Controlled Substance Prescription Monitoring Program (CSPMP)</li> <li>- Review existing policies and procedures ensuring other sources of funding are utilized first when available</li> <li>- Identify training topics and secure training related to integrated behavioral health, care coordination, integrated strength based treatment planning, screening and assessment for co-occurring disorders, and recovery support.</li> </ul>	Lesley Wimmer Kelly (lead), Jane Dowling, MMIC, C-IC, Community Medical Services, COPE

Months post grant award	Key Activities/Milestones	Responsible Staff
	- Develop workgroup with goal of leveraging existing partnerships and data sharing agreements to develop a system for identifying and transitioning MAT eligible clients associated with criminal justice system to community based MAT Providers.	
	5. Finalize Evaluation Plan (including process and outcome evaluation plan and data system for evaluation data) with Wellington	Lesley Wimmer Kelly, Jane Dowling
	6. Develop and submit Health Disparities Impact Statement submitted to SAMHSA	Lesley Wimmer Kelly, Jane Dowling
Three months post award	7. Hire additional positions related to project (i.e. Correctional Health Liaison, Peer Support, etc.)	Community Medical Services and COPE
	8. Train Community Medical Services and COPE staff on GPRA and data collection	Jane Dowling
	9. Begin service delivery	MMIC, C-IC, Community Medical Services and COPE
Four months post award	10. MAT Provider staff will attend training on Moral Reconation Therapy	Community Medical Services and COPE
	11. Implement Process & Outcome Evaluation Plans	Jane Dowling
Monthly	12. Project oversight phone call (occurring at minimum monthly for the first 6 months)	Lesley Wimmer Kelly (lead), Jane Dowling, MMIC, C-IC, Community Medical Services, COPE
	13. Analyze CSAT GPRA Client Outcome Measures	Lesley Wimmer Kelly and Jane Dowling
	14. Receive, analyze, and respond to monthly summary report	Lesley Wimmer Kelly and Jane Dowling
	15. Track number of outreaches, percentage of admissions from outreach, and percentage of subsequent treatment plans implemented, percentage abstinent at 6 months, and percentage of revocations	Jane Dowling
Quarterly	16. Identify training topics and secure training related to integrated behavioral health, care coordination, integrated strength based treatment planning, screening and assessment for co-occurring disorders, and recovery support.	Lesley Wimmer Kelly (lead), Jane Dowling, MMIC, C-IC, Community Medical Services, COPE
	17. Project oversight phone calls (if appropriate after 6 months of project implementation)	Lesley Wimmer Kelly (lead), Jane Dowling, MMIC, C-IC, Community Medical Services, COPE
	18. Review progress toward workgroup with goal of leveraging existing partnerships and data sharing agreements to develop a system for identifying and transitioning MAT eligible clients associated with criminal justice system to community based MAT Providers.	Lesley Wimmer Kelly, MMIC, C-IC, Community Medical Services, COPE, Jane Dowling
Bi-annual	19. Bi-annual reports due to SAMHSA	Lesley Wimmer Kelly and Jane

Months post grant award	Key Activities/Milestones	Responsible Staff
		Dowling
	20. Site Reviews	Lesley Wimmer Kelly/Lead Evaluator
Annually	21. Performance benchmarks will be reviewed and reestablished annually, if needed	Lesley Wimmer Kelly and Jane Dowling
	22. Track the number of completed eligibility screenings annually	Jane Dowling
	23. Administer Wilder Collaboration Factors Inventory to project partners at baseline and annually.	Jane Dowling
On-going	24. Assess project implementation, provide and coordinate technical assistance as needed	Lesley Wimmer Kelly, Jane Dowling

**C2:** The communities for this project are final and both regional behavioral health authorities (RBHAs) have agreed to participate in the program. The RBHA for Maricopa County is Mercy Maricopa Integrated Care (MMIC) and the RBHA for Pima County is Cenpatico Integrated Care (C-IC). MMIC has identified Community Medical Services as the MAT provider for Maricopa County and C-IC has identified COPE Community Services (COPE) as the MAT provider for Pima County. In addition to the RBHAs and providers, Maricopa County Correctional Health Services (CHS) understands the importance of coordinating post-release treatment. CHS understands that they will not receive any funding through this project and has committed to collaborating with MMIC and Community Medical Services to achieve the goals of this project. CHS and MMIC have worked together to coordinate behavioral health services upon release for Medicaid eligible members and will build upon those collaborative efforts for this project. CHS provides medical and behavioral health care, including MAT services through four of its jail-based Opioid Treatment Programs, to individuals in the Maricopa County jail system. CHS is committed to coordinating the treatment of individuals in their care with MMIC and Community Medical Services for the purposes of this program, including allowing Community Medical Services to outreach and screen incarcerated individuals eligible for MAT while incarcerated within four months of release. While a partnership to the extent of the one between MMIC and CHS does not yet exist between C-IC and correctional facilities in Tucson, the goal is to develop that partnership through this grant project.

#### **How the chosen communities will implement the program:**

MMIC and C-IC (the RBHAs) will be expected to identify existing staff that will be involved in this project and responsible for facilitating and supporting the collaboration between the MAT provider and criminal justice entities. Additionally, the RBHA's Substance Use Program Coordinators will be expected to attend collaboration meetings and assist the providers as needed. These positions are existing positions at the RBHAs and it is not anticipated that they will need to hire additional staff to support this project.

The RBHAs will be responsible for sharing the program eligibility criteria for this project (individuals that are not currently eligible for Medicaid and have current opioid use, opioid use within the 12 months prior to incarceration, or individuals that are currently receiving MAT during incarceration) with criminal justice entities in their geographic service area. In the event

that an individual is interested in receiving MAT but does not meet the eligibility criteria for this project, they will be referred to customer service at the RBHA responsible for their county of residence to be screened for program/funding eligibility. Regardless of funding, individuals qualifying for MAT services will be provided with the information of MAT providers available in their county of residence.

The MAT providers currently have a wide range of staff as required of OTPs by 42 CFR § 8.2, including but not limited to physicians, nurses, counselors, and case managers that are all appropriately licensed and trained for the level of care provided. The number of positions varies based upon the acuity and number of patients enrolled at the clinic. In addition to Federal and State licensing requirements AHCCCS requires the RBHAs to ensure their contracted providers, including OTPs, maintain staffing and a facility that is adequate to ensure quality patient care and to meet the requirements of all pertinent Federal, State, and local laws and regulations. The MAT Providers involved in this project will be expected to hire additional clinical staff as needed to support this project and maintain reasonable case loads. The providers will be expected to hire a Correctional Health Liaison that will focus their full-time efforts on this project. The Correctional Health Liaison will be responsible for the outreach and engagement of incarcerated individuals determined eligible for this project. Additionally, the Correctional Health Liaison will be the point of contact for coordination with criminal justice entities, both in identifying eligible individuals and coordinating post-release treatment. AHCCCS supports a recovery oriented system of care and understands the important role that peers play in recovery support. Therefore the providers are expected to incorporate Peer Support throughout the continuum of treatment, with peer support services available to individuals at all levels and intensity of services. Providers will be expected to involve individuals with lived experience in designing their program, designing their service delivery, and in the implementation and evaluation of their services and programs.

Upon projected release, the Correctional Health Liaison would meet with the client and the jail treatment team. This collaborative team would identify the needs of the individual including, develop a treatment plan, and identify available resources in the community to meet the individual's need. The Correctional Health Liaison will continue to outreach the individual and participate in any clinical staffings until the individual's release to ensure warm handoff to the outpatient treatment.

Once the release date has been identified, the provider will facilitate transportation from jail or prison to the individual's intake appointment at the provider. The provider will arrange for the Peer Support specialist to be present during transportation and to be available to stay throughout the intake process if the client requests their presence. This appointment will include a comprehensive psychosocial assessment and assessment utilizing the ASAM Criteria. At time of intake, the Case Manager will screen for public and private insurance and will assist individuals with the application for Medicaid or other coverage as applicable. Providers will follow the expectations for third party liability and coordination of benefits outlined in AHCCCS' policy manual. Providers will inquire about each person's coverage by other health insurance plans during the initial intake process. If an individual is eligible for Medicaid or services through the Substance Abuse Prevention and Treatment Block Grant (SABG), they can remain in treatment

at the provider agency but their MAT services would then be covered through Medicaid or SABG.

After the assessment, the Case Manager will discuss available services within the provider agency, including individual counseling, Moral Reconciliation Group therapy, and MAT services. Additionally, they will review community support services available to individuals to ensure comprehensive support is in place. Once a treatment plan has been developed, they will be seen by the provider's medical practitioner and evaluated for appropriate MAT. The Case Manager will meet with the client to address any questions and ensure that client has adequate support services in place.

The individual's assigned Case Manager will obtain the individual's consent to coordinate care with other individuals or agency's involved in the individual's care (i.e., primary care physician, residential treatment facility, probation or parole officer, Department of Child Safety, or any individual or entity that the individual identifies as a support for recovery). This coordination is crucial to facilitating a collaborative team-based approach to treatment and recovery.

In the event that co-occurring medical conditions are identified, during assessment or any time throughout the course of treatment, the individual will be referred to their primary care physician or to community health centers near them. Additionally, if during the assessment a mental health need is identified that cannot be addressed by the provider agency, such as a need for Psychiatric Medication management or the presence of a Serious Mental Illness, the Case Manager will contact their RBHA to obtain appointments with providers that can address the mental health needs of the individual.

If a residential level of care is indicated as the most appropriate level of care for the individual through the initial or subsequent ASAM Criteria assessment, the Case Manager at the provider will discuss with the individual the benefits to a higher level of care. If the individual agrees to participate in a residential program the Case Manager will submit a referral to the RBHA and the RBHA will inform the Case Manager of residential treatment availability. In the event that the individual will have a wait for residential services, the Case Manager will develop a plan to provide the individual with intensive support services while awaiting placement. The Case Manager will maintain coordination with the residential treatment facility through the duration of residential treatment to ensure transportation and level of care placement are not a barrier to the individual attending appointments required through their MAT treatment program.

In instances where an individual is being referred for medical care, mental health care, or residential treatment the provider can arrange for transportation to these appointments to ensure lack of transportation is not a barrier to individuals receiving necessary care.

During assessment the Case Manager will screen the individual for tobacco use and if an individual reports tobacco use the Case Manager will discuss Tobacco Cessation with them and will provide them Tobacco Cessation resources from the Center for Disease Control (<http://www.cdc.gov/tobacco/campaign/tips/partners/health/mental/index.html>) as well as Arizona's ASHLine (<http://ashline.org/>). The ASHLine contains a comprehensive collection of online cessation resources as well as a toll-free number that allows individuals to speak with a

Quit Coach to assist with their tobacco cessation. Additionally the ASHLine provides information on nicotine replacement therapies and provides guidance on how to obtain these medications at low or no cost to the individual.

After the intake, the MAT Providers will be responsible for the provision of services identified on the individual's treatment plan, including but not limited to the monitoring of MAT for Opioid Use Disorders, individual counseling, MRT Group therapy, peer support services, case management, and other recovery support services identified during treatment planning. The provider will be required to update individuals' assessments and treatment plans in accordance with requirements identified in MAT Provider's contract and requirements identified in AHCCCS' Contractor Operations Manual.

**How the state will work with the communities to achieve the goals of the program:**

The Project Director at AHCCCS will provide statewide administrative oversight and ensure program requirements are being met across the project service areas. The responsibilities of the AHCCCS Project Director are as follows:

- AHCCCS will assist MMIC, C-IC, and their providers in collaborating with criminal justice entities (including but not limited to drug courts, probation, parole, county jails, and prisons) to ensure coordination between provider staff and criminal justice entities. AHCCCS will leverage existing data sharing agreements with criminal justice entities to ensure RBHAs are notified when individuals eligible for this program are arrested or within four months of release from incarceration.
- AHCCCS will advocate the importance of integrated care, care coordination, recovery supports, strengths-based treatment planning, and a collaborative team approach to treatment. Furthermore, AHCCCS will help RBHAs and local providers develop implementation plans and protocols for delivering integrated care, care coordination, recovery supports, strengths-based treatment planning, and a collaborative team approach to treatment.
- AHCCCS will continue to advocate the importance of utilizing evidence-based MAT treatment in the community and within the RBHAs. AHCCCS will continue to require the RBHAs to maintain a network of MAT providers for their geographic service areas. Additionally, AHCCCS will maintain an open dialogue with the RBHAs regarding barriers to expanding MAT providers and will support the RBHAs in identifying solutions to overcome these expansion barriers.
- AHCCCS will expect the providers to implement EBPs listed in this application and will provide workforce development trainings as needed in existing or any additional EBP that would be needed to address subpopulation disparities.
- AHCCCS will arrange for trainings related to MAT services for criminal justice entities or other system stakeholders as needed in order to reduce stigma and increase awareness, understanding, efficacy, and outcomes of MAT services.



- AHCCCS will share project goals, objectives, initiatives, and outcomes with criminal justice and healthcare (both behavioral and psychical health) providers statewide to encourage a statewide coordination of effort.

**C3:** Beginning July 1, 2016, AHCCCS will serve as the Single State Authority on substance abuse, providing oversight, coordination, planning, administration, regulation and monitoring of all facets of the public behavioral health system in Arizona. AHCCCS contracts with three RBHAs to oversee the provision of behavioral and physical health services across the state. This structure allows organizations to provide services in a manner appropriate to meet the unique needs of individuals and families residing within their respective areas. Each RBHA is responsible for client evaluation and diagnosis, service and treatment planning, case management, coordination with the physical health care providers, and providing all behavioral health services through contracts with behavioral health providers. Both MMIC and C-IC are for-profit managed care organizations. Their providers, Community Medical Services and COPE, are both OTPs and for-profit organizations.

**C4:** AHCCCS has an annual Cultural Competency Plan which outlines goals, strategic plan timelines and initiative activities with measurable outcomes including the National Standards for Culturally and Linguistically Appropriate Services (CLAS). The work plan is a “living” document which allows for modifications to projects, activities and accomplishments as goals are reached, gaps are identified, and needs are met with the overall goal of improving culturally and linguistically competent coordination of care and provision of services to individuals accessing and receiving services. As of July 1, 2017, AHCCCS will require each contractor to have a comprehensive cultural competency plan outlined in AHCCCS Contractor Operations Manual.

#### Education and Training

Upon hire, all RBHAs and contracted providers employees must complete the required trainings such as *Cultural Competency 101: Embracing Diversity, Culturally Linguistically and Appropriate Services* (CLAS Standards) and *Limited English Proficiency (LEP)* courses that are designed to address the importance of providing services in a culturally competent and linguistically appropriate manner. RBHAs also offer continuing education in Cultural Competency. Examples that are currently being used in the system are: (1) *Demographic and Outcome Data User Set Data Elements 109 (Gender Identity) and 110 (Sexual Orientation)*; (2) *Child Family Team Strengths, Needs, Cultural Discovery*; (3) *In Our Own Voice*; (4) *Interpretation and Translation Services: Meeting the Needs of LEP Members*; (5) *Cultural Wisdom: The Indigenous World View as a Model for Social and Environmental Justice*; (6) *A Culture-Centered Approach to Recovery*; and (7) *Military Cultural Competence*.

#### Culturally Competent Services and Care

Family-Centered Care is integral to service planning. Providers are required to discuss culture with the individual and/or family and incorporate cultural factors in service planning. Monitoring of cultural indicators of the quarterly Quality Management Aggregate data for adult and children providers occurs on a regular basis. Also, the Annual Network Inventory is conducted to ensure that the network broadly represents the demographics of our diverse population (cultural, linguistic and disability related services).

### Language Access Services: Translation and Interpretation Services

Understanding the impact and importance of cultural and linguistic needs of individuals accessing and receiving service in the mental health system supports the whole health and wellness of the individual. When seeking and receiving services, individuals are advised and/or informed of their right to receive interpretation and translation services at multiple points of the service delivery process. Examples: delivery of rights at intake and assessment; Member Handbook delivery, member's rights and responsibilities, consent form containing information of right to interpretation and translation services; and vital documents and forms contain information about interpretation and translation services. AHCCCS has developed a monitoring system to ensure members have been informed of their right to receive interpretation and translation services into their preferred language.

### Services gaps and or needs

The process to identify service gaps and or needs includes assessing and evaluating the potential service needs among diverse populations through a variety of methods including focus groups, surveys, and data collection. The information is analyzed and action is taken to correct any identified deficiencies.

**C5:** AHCCCS supports a model of assessment, service planning, and service delivery that is strength-based, person-centered, family friendly, culturally and linguistically appropriate, and clinically sound. The model is based on four equally important components: input from the person regarding their individual needs, strengths, and preferences; input from other persons involved in the person's care who have integral relationships with the person; development of a therapeutic alliance between the person and behavioral health provider that fosters an ongoing partnership built on mutual respect and equality; and clinical expertise. Ongoing collaboration, including the communication of appropriate clinical information, with other individuals and/or entities with whom delivery and coordination of services is important to achieving positive outcomes (e.g., primary care providers, school, child welfare, criminal justice entities, other involved service providers) as well as oversight to ensure continuity of care by taking the necessary steps (e.g., clinical oversight, development of facility discharge plans, or after-care plans, transfer of relevant documents) to assist persons who are transitioning to a different treatment program, (e.g., residential to outpatient setting), changing behavioral health providers and/or transferring to another service.

All individuals participating in this program must have an assessment completed at time of enrollment to document clinical need for services. This assessment will collect information regarding the presence of co-occurring medical, mental health, and substance use. This information will inform providers of how to plan for effective care coordination and treatment of the individual. AHCCCS does not mandate that a specific assessment tool or format be used but requires certain minimum elements including the following information:

- a) Presenting concerns;
- b) History of present illness, including review of major psychiatric symptoms (i.e., mood, depression, anxiety, psychosis, suicidal ideation, homicidal

- ideation, and other behavioral health symptoms) and frequency/duration of symptoms;
- c) Psychiatric history, including history of previous psychiatric hospitalization(s) and psychotropic medication trial(s);
  - d) Medical history, current medications, including over the counter (OTC) medications, allergies and other adverse reactions;
  - e) Legal history, including pending litigation, Court Ordered Evaluation/Court Ordered Treatment (COE/COT) history, criminal justice history;
  - f) Substance use history including type of substance, duration, frequency, route of administration, longest period of sobriety, and previous treatment history;
  - g) Substance use screen for adults age 18 and older using the American Society of Addiction Medicine (ASAM) Criteria Third Edition);
  - h) Cultural needs (i.e. age, ethnicity, race, national origin, sex, gender, gender identity, sexual orientation, tribal affiliation, disability);
  - i) Risk assessment;
  - j) Family history;
  - k) Educational history/status;
  - l) Employment history/status;
  - m) Housing status/living environment;
  - n) Social history;
  - o) Mental status examination;
  - p) Bio-psycho-social formulation;
  - q) Diagnoses codes.

Additionally clinicians are responsible for collecting the contact information for the individual's Primary Care Provider's name and any other involved agency (e.g., Probation) in order to facilitate effective coordination of care. For individuals with Limited English Proficiency (LEP) the assessment must also contain the individual's linguistic needs (i.e. primary language, preferred language, language spoken at home, alternative language).

AHCCCS requires in its contracts with the RBHAs that all individuals with a diagnosed substance use disorder be assessed utilizing the ASAM Criteria, to ensure a holistic, person-centered approach is taken in developing treatment plans and level of care referrals.

**C6:** Upon initial assessment with MAT Provider agency individuals will be involved in the treatment planning process. Case Managers will inform individuals of substance use and integrated treatment services and the individual will identify and agree to services they are willing to engage in. The Case Manager will be responsible for referring and coordinating care as needed. The medical prescriber will conduct a medical assessment on each individual and determine the most clinically appropriate medication option to treat each individual's opioid use disorder. The medical prescriber will discuss medication assisted treatment options with the individual and will take into consideration the individual's choice as well as clinical appropriateness before finalizing a treatment regimen. The medical prescriber will inform each individual of the potential risks and benefits of the identified treatment regimen.

AHCCCS will require MMIC and C-IC to conduct record reviews to evaluate compliance with standards and to evaluate the quality of care provided by the providers. Monitoring and evaluation will occur through quality management activities that will occur monthly and quarterly, such as direct data reports from provider, focused ad hoc reviews, and annual administrative reviews.

The purpose of the provider monitoring process is to continuously evaluate the service delivery system of this project to promote improvement in the quality of care provided to behavioral health recipients in all levels of care. To affect change and initiate improvements at all service sites, AHCCCS requires the RBHAs to conduct on-site provider monitoring for all subcontractors at least annually; more frequent provider monitoring may take place for subcontractors demonstrating performance below minimum standards and as data evaluation indicates. Other monitoring activities must include regular subcontractor reporting and provider profiling.

MMIC and C-IC are each accountable for the administrative and clinical integration of physical and behavioral health services for individuals with Serious Mental Illness, behavioral health services for all other eligible populations, and coordination of Medicare and Medicaid benefits for dually eligible members in their geographic service areas. Individuals participating in this project that do not qualify for Medicaid and have no other health insurance will be referred to Federally Qualified Health Centers (FQHCs) or FQHC-lookalikes by their Case Manager at the provider.

**C7:** The State Opioid Treatment Authority (SOTA) is housed within AHCCCS. The SOTA/AHCCCS work closely with the Division of Licensing Services (DLS) at the Arizona Department of Health Services, and SAMHSA's Division of Pharmacologic Therapies (DPT) to ensure OTP compliance with federal and state regulations. DLS provides yearly oversight and monitoring of all providers in Arizona, including MAT providers involved in this project, to ensure the compliance of State and Federal regulations. During these monitoring visits DLS will ensure that the facilities have a policies and procedures established ensuring personnel has required certifications or credentials for the services being offered and provided, Health Insurance Portability and Accountability Act of 1996 (HIPAA) practices/policies in place for protection of patient rights, ensuring the agency's medical records are inclusive and included required health information of State and Federal regulations. All outpatient OTPs in Arizona, in compliance with federal regulations, obtain and maintain Commission on Accreditation of Rehabilitative Facilities (CARF) accreditation. As a result the MAT Providers in this project, Community Medical Services and COPE Community Services, have diversion control plans outlining specific diversion control measures that will be used (i.e., medication callbacks) in accordance with 42 CFR 8.12(c)(2). The RBHAs are expected to routinely audit their providers to ensure adherence to State and Federal regulations. Through these routine audits MMIC and C-IC will review policies and procedures, including diversion control plans, of the MAT providers involved in this project and will provide technical assistance as needed. The RBHAs will provide the Project Director at AHCCCS a copy of their reports.

Further, Arizona Revised Statutes (A.R.S.) § 36-2606 requires each medical practitioner who is licensed under Title 32 and who possesses a DEA registration to also possess a current controlled substances prescription monitoring program registration issued by the Arizona State Board of

Pharmacy (ASBP). AHCCCS will require that the medical staff at the MAT Providers involved in this project are checking the Controlled Substance Prescription Monitoring Program (CSPMP) at least monthly to review and verify medications prescribed by prescribers outside of the MAT Provider and identify any potential for contraindicated prescribing. Copies of each individual's CSPMP record will be kept in the individual's electronic health record or chart.

**C8: Identify:** MMIC and C-IC will inform criminal justice entities (including but not limited to probation, parole, drug courts, and correctional health departments in the county jails and state prisons) in their counties of the eligibility criteria for this project and provide them with the contact information for the Correctional Health Liaison at the MAT provider. The eligibility criteria for this project are individuals that are not currently eligible for Medicaid and have current opioid use within 12 months prior to incarceration, or individuals that are currently receiving MAT during incarceration. Through existing data sharing agreements between criminal justice entities and the RBHAs, the criminal justice entities will notify the RBHA and its provider of individuals eligible for services through this project.

**Engage:** The Correctional Health Liaison will coordinate with applicable criminal justice entity and begin outreaching identified individuals to screen their eligibility for the program and provide the individual information regarding MAT and the services available through this grant. The Correctional Health Liaison will utilize Motivational Interviewing skills to engage and build rapport with the identified individuals. If an individual that is currently incarcerated expresses interest in MAT services upon release, the Correctional Health Liaison will begin attending meetings with the individual's treatment team to ensure a seamless transition into outpatient services. If an individual that is not currently incarcerated expresses interest in MAT services, the Correctional Health Liaison will arrange an appointment and transportation, if needed, for the individual.

**Retain:** The program will provide the full range of MAT treatment services including the prescribing and dispensing of MAT medication, case management, peer support, and counseling services. In addition, Moral Reconnection Therapy groups and transportation will be available. In order to retain individuals for evaluation purposes, the program will offer gift card incentives, in compliance with FOA limitations, after completed GPRA interviews at six months and discharge.

Language, belief, norms, and values	A culturally diverse staff; use of Peer Support Specialists; workforce development to support training, education and outreach to health care providers and individuals working in the criminal justice system
Socioeconomic	Each individual will be assessed for eligibility for Medicaid and offered employment services
Medical	RHBAs and local providers will develop implementation plans and protocols for delivering integrated care, care coordination, recovery supports, strengths-based treatment planning, and a collaborative team approach to treatment

**C9:**

	Organization	Roles/Responsibilities	Capacity to fulfill responsibility
RBHAs Currently Contracted with AHCCCS	Mercy Maricopa Integrated Care (MMIC)	1. Participating in collaboration between MAT provider and criminal justice entities in their respected county 2. Monitor the MAT Provider in their county in accordance with the RBHAs monitoring practices	1. RBHAs currently have Criminal Justice Liaisons and established meetings 2. Utilize current processes in place (QI department) 3. Utilize current process established by RBHAs
	Cenpatico Integrated Care of Arizona (C-IC)	3. Ensure access to member services 4. Coordinate any transfer requests initiated by enrolled individuals 5. Educate enrolled members of other providers available in their county of residence	4. Utilize current transfer policy 5. Utilize current communication plan at RBHA level 6. RBHA staff are available for technical assistance (TA) as needed
MAT Providers (currently contracted with the respective RBHAs)	Community Medical Services (MMIC)	1. Provision of services identified on individuals treatment plan (including but not limited to the monitoring of MAT for Opioid Use Disorders, individual counseling, MRT Group therapy, peer support services, case management, and other recovery support services)	1. Adhere to current process outlined in AHCCCS Operational Manual and federal regulations
	COPE Community Services (C-IC)	2. Establish/implement Recovery Advisory Boards 3. Participate in collaboration between MAT provider and criminal justice entities 4. Data collection outlined in Section E: Data Collection and Performance Measurements	2. Established MAT Provider will work with leadership and MAT Grant team to develop and implement 3. Participate in all scheduled meetings 4. Lead Evaluator will provide TA as needed
Lead Evaluator	Wellington Consulting Group	Responsible for overall data collection, analysis and reporting outlined in Section E: Data Collection and Performance Measurement	Evaluation team has over 30 years of experience of research and evaluation. The team is also cross-trained in every project.
Criminal Justice Entity	Maricopa County Correctional Health Services (CHS)	Committed to collaborating with MMIC and Community Medical Services to achieve the goals of this project. CHS will not receive funding through this project.	Has current staffing and programs to assist with strengthening the coordination of care for MAT services for inmates being released from jail.

**C10:** The Arizona MAT-PDOA Criminal Justice Project proposes to serve a total of 80 unduplicated individuals, annually and a total of 240 over the 3 year program period. The types of services to be provided include but are not limited to: assessment; medication evaluation, administration and management of clinically appropriate medication assisted treatment for opioid use disorders; group and individual counseling; case management and care coordination; peer support and other recovery support services; and transportation. The numbers of these services will be determined by the clinical treatment team and delivered at a frequency that is determined clinically necessary. Anticipated outcomes of the project include: increasing the number of admissions of individuals with opioid use disorders (OUD) into MAT services, increasing access to integrated care and treatment for individuals with OUD, a decrease in illicit opioid drug use at

six month follow-up, a decrease in the use of prescription opioids in a non-prescribed manner, a decrease in recidivism among criminal justice involved individuals involved in treatment through this project, increased knowledge and understanding of evidence-based MAT services amongst the criminal justice community, and increased collaboration between MAT Providers and criminal justice entities across the state.

After conducting a data analysis of members enrolled in the public behavioral health system in Arizona that were determined MAT-eligible with an Opioid Use Disorder as an Axis I diagnosis that received behavioral health services funded through Medicaid, Federal Block Grants (SABG/MHBG), Federal Discretionary Grants, or State funds) during FY15, the number of individuals projected to be served by this grant through the three project years are identified below:

	FY 2017	FY 2018	FY 2019
<b>Projected number of individuals to be served</b>	80	80	80
<b><i>By Primary Substance Type</i></b>			
Heroin/Morphine	45	45	45
Other Opiates	18	18	18
Other substance types	17	17	17
<b><i>By Race/Ethnicity</i></b>			
African American	2	2	2
Asian	1	1	1
Native American	2	2	2
Native Hawaiian/Pacific Islander	1	1	1
White	71	71	71
Two or more Races	1	1	1
Unknown	2	2	2
<b><i>By Ethnicity</i></b>			
Hispanic/Latino	19	20	20
Non-Hispanic/Latino	59	59	59
Unknown	2	2	2
<b><i>By Gender Identity</i></b>			
Gender Variant	1	1	1
Intersex	1	1	1
Man	38	38	38
Questioning	3	3	3
Transgender	1	1	1
Woman	33	33	33
Unknown	3	3	3
<b><i>By Sexual Orientation Status</i></b>			

Asexual	1	1	1
Bisexual	1	1	1
Gay or Lesbian	3	3	3
Heterosexual	67	67	67
Questioning	2	2	2
Unknown	6	6	6
<b><i>By Age Groups</i></b>			
18-20 years old	3	3	3
21-25 years old	13	13	13
26-29 years old	13	13	13
30-34 years old	14	14	14
35-39 years old	10	10	10
40-44 years old	6	6	6
45-49 years old	6	6	6
50-54 years old	6	6	6
55-59 years old	5	5	5
60 years old and older	5	5	5

NOTE: "Unknown" includes those members who declined to answer or where the demographic field was not indicated.

**C11:** The MAT Providers will be reimbursed for services delivered once individuals are released from incarceration and have been formally assessed and enrolled in the program. When billing for services, the MAT Providers will be required to utilize AHCCCS' Behavioral Health Rates<sup>20</sup> which are the amount providers and the RBHAs are allowed to bill AHCCCS for behavioral health services provided to enrolled individuals. These contracted rates apply to all providers regardless of the funding source covering the service (e.g., Medicaid, Substance Abuse and Mental Health Block Grants, State funds). To estimate the per-participant cost for this program; the total amount being allocated annually for service delivery (\$758,000) was multiplied times three to project the anticipated service delivery amount over the three years of the grant project. That number (\$2,274,000) was then divided by the number of unduplicated individuals to be served over the lifetime of the grant (240) to obtain the per-participant cost over the lifetime of the grant. Based on these calculations AHCCCS anticipates the amount of funding available per-participant over the lifetime of the grant to be \$9,475.

Remaining funds will be utilized for personnel costs, training, workforce development, travel for required project activities, project evaluation activities, and program incentives at the provider level. The training conducted through this project will be paid for by AHCCCS.

<sup>20</sup> AHCCCS Behavioral Health Rates

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/BehavioralHealthrates.html>



**C12:** AHCCCS is not applying for \$1 million as there is not currently a certified Electronic Health Record (EHR) being utilized throughout the state.

**Section D: Staff and Organizational Experience (10 points)**

**D1:** Arizona has a long history of implementing significant and innovative initiatives related to integration and care coordination in the provision of physical and behavioral health services. Through an administrative initiative to integrate the administration of physical and behavioral health services as of July 1, 2016, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) and the Arizona Health Care Cost Containment System (AHCCCS) will merge to fully integrate the implementation and oversight of federally funded behavioral and physical care services. The integration of ADHS/DBHS and AHCCCS builds stronger and better informed delivery of behavioral and physical health services through Arizona's Medicaid and SAMHSA programs.

In addition to overseeing the managed care organizations that provide Medicaid-funded physical health care services, AHCCCS will now serve as the Single State Authority on substance abuse. AHCCCS will be the single agency responsible for matters related to behavioral health and substance abuse and will provide oversight, coordination, planning, administration, regulations, and monitoring of all facets of the public behavioral health system in Arizona. Through this integration the staff responsible for the application, implementation, and oversight of SAMHSA block and discretionary grants have transitioned from ADHS/DBHS to AHCCCS. These positions include the SOTA/Opioid Treatment Network and National Treatment Network representatives. With the integration of physical and behavioral health services within one state agency, AHCCCS is in a position to use the outcomes from the grant to develop next steps in moving statewide in expanding MAT treatment, increasing enrollment in MAT services, and improving treatment outcomes for individuals with an opioid use disorder.

AHCCCS currently contracts with three RBHAs to administer integrated managed care delivery services in three distinct geographic service areas (GSAs) throughout the State. This regionalized system allows local communities to provide services in a manner appropriate to meet the unique needs of individuals and their families. In FY 2014 the RBHAs served over 221,000 individuals in the public behavioral health system. AHCCCS requires RBHAs to maintain a comprehensive network of behavioral health providers that deliver prevention, intervention, treatment and rehabilitative services to a variety of populations including children and adolescents, Adults with Serious Mental Illnesses (SMI), adults with General Mental Health Disorders (GMH), and persons with Substance Use Disorders (SUD/SA).

AHCCCS recognizes the interconnectivity of an individual's physical health and behavioral health and the importance to assist and promote whole body healthcare for all Arizonans. AHCCCS has supported integrated healthcare through various activities including educating healthcare providers, policy makers and the community as well as addressing systemic barriers to integration. All three RBHAs are fully responsible for coordinated and integrated behavioral and physical healthcare for Medicaid eligible adults with SMI.

**D2: Mercy Maricopa Integrated Care:** Mercy Maricopa Integrated Care (MMIC) is locally owned and operated organization that administers the public behavioral health system in

Maricopa County and parts of Pinal County who is contracted with the State of Arizona. MMIC is sponsored by Mercy Care Plan and Maricopa Integrated Health System. They have a wide network of community providers that offer behavioral and physical health care, peer- and family-run services, crisis intervention and substance abuse and suicide prevention. This network provides our members the services and supports they need to reach their recovery goals. MMIC also receives other federal funding from the State, including block grant funding and discretionary grants.

MMIC administers care for individuals (95,894 currently enrolled in an episode of care) who are diagnosed with a serious mental illness, other adult, child and adolescent members with general mental health and substance use disorders, most of whom are Medicaid or Medicare eligible. MMIC also oversees the crisis system that serves all Maricopa County residents. MMIC also receives other federal funding from the State, including block grant funding and discretionary grants.

**Community Medical Services:** Community Medical Services has been providing behavioral health treatment for individuals with an opioid use disorder in Arizona since 1983. Community Medical Services is currently contracted with both MMIC and C-IC to provide Medication Assisted Treatment for individuals with an opioid use disorder and receives both Medicaid and Substance Abuse Prevention and Treatment Block Grant funding. Community Medical Services has three locations in the Phoenix metropolitan area, a clinic in the Tucson area, and three clinics in Montana. Community Medical Services is currently spearheading collaborative projects with Arizona Department of Corrections, Maricopa County Superior Court and Drug Court, Maricopa County Correctional Health Services, Department of Child Safety, Veterans Affairs, and multiple residential treatment programs throughout Arizona.

**Cenpatco Integrated Care:** C-IC is an Arizona-based, locally-operated managed health services company dedicated to ensuring that enrolled members receive ready access to high quality, integrated, and culturally responsive care. C-IC is comprised of Cenpatco Behavioral Health of Arizona and University of Arizona Health Network. These two organizations bring 25 years collective experience providing behavioral and physical healthcare in eight counties Southern Arizona. C-IC is contracted with State of Arizona and receives other federal funding from the State, including block grant funding and discretionary grants. C-IC offers a robust provider network of behavioral and physical health providers their members including whole person health care, providing both medical and behavioral services to people who have been designated as having a serious mental illness, general mental health and substance abuse, and child and adolescent services For over 51,267 individuals enrolled in an episode of care.

**Cope Community Services:** COPE Community Services has a long history in the Tucson community of providing services to person with substance use disorders: using MAT, therapeutic interventions and support services. COPE has also been serving members at their Outpatient Methadone clinic since 2005. COPE has a contract with C-IC in Pima County and receives both Medicaid and Block Grant funding to serve the community.

**Wellington Consulting Group:** Dr. Dowling and her team at Wellington have extensive experience working with communities, non-profit agencies as well as federal, state, and local

governmental agencies and possess full recognition of the unique requirements of federal grant programs, e.g. GPRA requirements. The Evaluation Team is currently evaluating the work of three Drug Free Community Coalitions, multiple Substance Use Prevention programs, and two treatment grants in Arizona funded through SAMHSA. The team is also recently completed successful evaluation of two Project LAUNCH programs in Arizona and Texas, funded by SAMHSA.

**Maricopa County Correctional Health:** CHS provides medically necessary, integrated healthcare to individuals housed in the Maricopa County Jails. They serve a population which often has had little or no access to health care. Many individuals' needs are related to chronic physical and mental health conditions. Most of the population in the jails is pre-trial; some are sentenced for one year or less. Every person housed in the Maricopa County jails is eligible for care. CHS currently starts MAT for opioid addicted pregnant females entering the jail system, along with maintaining male and female patients already on methadone from the community after verification with their respective outside OTP offices.

**D3: Project Director:** Lesley Wimmer Kelly has been an Implementation Manager within the System of Care/Grants division at ADHS/DBHS and now AHCCCS for a year and a half. During this time Ms. Wimmer Kelly has been responsible for the coordination, implementation, and oversight of initiatives and projects related to treatment under the Substance Abuse Prevention and Treatment Block Grant (SABG). Ms. Wimmer Kelly will dedicate 50% of her time to this project and will be responsible for working with the RBHAs and MAT providers in the identified communities to achieve the goals of the program. This will include overseeing the implementation and monitoring of the project, ensuring the key activities and milestones are met.

**Lead Evaluator:** Dr. Jane Dowling will be responsible for leading the evaluation team from Wellington Consulting Group, Ltd. Dr. Dowling has been in the role of an evaluator for over 30 years and is the President/CEO of Wellington, a research and evaluation firm. The firm has multiple evaluation contracts with the State of Arizona on federal grant programs, including the CABHI-States and CABHI-States-Enhancement grants with ADHS/DBHS and AHCCCS. Dr. Dowling's level of effort will be .20 FTE. This level of effort is Dr. Dowling's historical level effort on previous grant projects with ADHS/DBHS and AHCCCS. Dr. Dowling and her team at Wellington are committed to completing necessary evaluation tasks to make this project successful regardless of Dr. Dowling's FTE.

**Correctional Health Liaison:** This is not currently a filled position. The MAT Providers will be required to hire this position upon grant award. The minimum requirements for this position will be 2 years working with individuals with substance use disorders as well as 2 years working with criminal justice involved individuals. This position will also require the individuals meet the Arizona requirements to Behavioral Health Technician and have experience conducting intakes and coordinating care. This position will be 1 FTE per MAT provider.

**Peer Support Specialist:** This is not currently a filled position. The MAT Providers will be required to hire this position upon grant award. The minimum requirements for this position will be for the individual to have lived experience with substance use disorder and criminal justice system involvement. This position will also require evidence of successfully navigating the

public behavioral health and criminal justice systems. This position will be 1 FTE per MAT provider.

**State Opioid Treatment Authority (SOTA):** This position is currently filled by Michelle Skurka. Ms. Skurka is the Office Chief of the System of Care/Grants division at AHCCCS and has over 6 years being designated as the SOTA. Ms. Skurka will not be funded through this grant but as Office Chief and SOTA will be involved in the administrative oversight as needed.

**D4: Project Director:** Lesley Wimmer Kelly has over eight years of experience as a clinician in the behavioral health system in Arizona's public behavioral health system working with adults with general mental health and substance use disorders. Ms. Wimmer Kelly currently serves as the Arizona representative for the National Treatment Network as well as the Project Director for the Cooperative Agreements to Benefit Homeless Individuals for States – Enhancement (CABHI-States-Enhancement) grant. Additionally Ms. Wimmer Kelly has six years coordinating grant related activities at Arizona State University.

**Lead Evaluator:** Dr. Jane Dowling will be responsible for leading the evaluation team from Wellington Consulting Group, Ltd. The firm has experience working with the target population having evaluated multiple programs funded through SAMHSA with the RBHAs in Arizona. Wellington is the current evaluator of the state's SBIRT program as well as the state's CABHI Programs. The firm's employees represent multiple races/ethnicities and are very familiar with the cultures found throughout Arizona. The firm also has the capacity to offer evaluation services in Spanish.

**D5:** Ensuring a system of inclusion of people in recovery and their loved ones in program planning, implementation, and assessment is essential to developing quality services that are client centered and recovery oriented<sup>21</sup>. Building the capacity of people in recovery to develop their stories, and provide policy stakeholders with education and recommendations, supports recovery oriented care and stigma reduction<sup>22</sup>.

As this is the case, the local MAT Providers will be responsible for assembling Recovery Advisory Boards (RABs) consisting of participants and their families in various stages of recovery. The goal of the RABs will be to review program protocols, reflect on services provided, and make recommendations on planning and implementing services. The RAB will meet monthly to provide care coordination, treatment recovery support staff, and the evaluator with the client perspective related to service gaps, outreach, recruitment, engagement, and treatment strategies, and the quality of the provider agencies used for referrals. Additionally, during the monthly meetings, the RABs will provide qualitative input on the impact of care coordination and recovery support services in increasing participation and access in MAT services, increasing abstinence for illicit and non-illicit opioid use, and decreasing recidivism.

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<sup>21</sup> Tondora, J. & Davidson, L., (2006). Practice guidelines for recovery-oriented behavioral health care. Hartford, CT: Connecticut Department of Mental Health and Addiction Services.

<sup>22</sup> White, W. (2009). Peer-based addiction recovery support: History, theory, practice, and scientific evaluation. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

RAB members will be asked to develop education presentations documenting their experience in obtaining and receiving MAT services, achieving recovery, and recommendations for system improvement including the inclusion of voices in recovery. Recovery support staff will help build the capacity of RAB members to develop and communicate their story of recovery. RAB members will be invited to participate in and educate the Arizona MAT-PDOA Criminal Justice Expansion Project stakeholders on their recovery experience.

Lastly, local MAT Provider program staff and RAB members will work together to help develop and facilitate MAT Recovery Support Fellowships, such as but not limited to Methadone Anonymous, etc. for enrolled participants and others receiving MAT services throughout Maricopa and Pima communities for medication assisted recovery to further support long term recovery and stigma reduction across the communities.

### **Section E: Data Collection and Performance Measurement (15 points)**

**E1:** The Lead Evaluator, Dr. Jane Dowling from the Wellington Group, Ltd. and her staff, has been involved in the evaluation of multiple SAMHSA service grants and is very familiar with the GPRA, its collection and reporting. Wellington currently collects GRPA data for the SBIRT project administered through the Governor's Office of Youth, Faith and Family and the CABHI-States and CABHI-States-Enhancement grants for the Arizona Department of Health Services, which will transfer to AHCCCS on July 1<sup>st</sup>. Dr. Dowling and her evaluation team staff enter the GPRA data into SAIS and are also very experienced with setting up data collection procedures and processes to ensure the timely submission of the required data on quarterly basis and the required annual or final report. Timelines are set up with the Project Team so data is collected, analyzed, interpreted and entered according to SAMHSA due dates.

Wellington will be responsible for overall data collection, analysis and reporting. Wellington staff have attended SAMHSA-sponsored training for the GPRA and will train project staff who will be administering the GPRA. Wellington staff will enter GPRA data into SAIS and will develop a web-based tracking log for providers to use in order to track administration of intake GPRA, 6-month follow-up and discharge. The log will be monitored by Wellington in order to ensure follow-ups are being conducted within the window to achieve an 80% rate. If follow-ups are due and have not been conducted, the provider will be contacted to determine the reason(s) the follow-up was not conducted when due. The Lead Evaluator will analyze the GPRA data on a monthly basis providing AHCCCS with a summary report including the following GPRA performance measures: abstinence from use, housing status, employment status, criminal justice system involvement, access to services, retention in services, and social connectedness. Frequency analysis and descriptive statistics will be utilized to confirm patterns associated with certain risk and protective factors. Frequency analysis will be used to provide demographic information. The monthly reports will be sent to the Project Director at AHCCCS and shared with the provider during the regularly scheduled monthly meetings. The 6-month follow-up rates will be calculated at the appropriate time periods. A summary of GPRA findings will be generated for the provider on a quarterly basis. Content analysis of monthly process narratives completed by the provider will be utilized to identify characteristics of recruitment / retention plans, factors that facilitate / hinder implementation, and challenges and barriers experienced and resolutions. This report will also be used to identify effective recruitment and retention and program implementation. Wellington will be responsible for monthly data reports for the

monthly provider meetings and will assist in the compilation of the biannual report on the progress and performance on achieving the goals and objectives.

In addition to the GPRA, three additional instruments will be used to track progress of the measurable objectives. The instruments include a training survey that will be a Retrospective Pre Assessment of Knowledge and a 6-month Actual Use Survey. These instruments will be developed after the training workshops are finalized (Objectives 2.1 & 3.2). These instruments will be used to measure the effectiveness of the training on providers and key stakeholders. A research-based collaboration inventory will be administered at baseline and then again annually to the members of the MAT-PDOA Criminal Justice Project. The Wilder Collaboration Factors Inventory will allow us to measure whether or not there is an increase in collaboration, coordination, and partnerships at the state, regional, and local levels.

**E2:** On a monthly basis, the providers will complete a web-based Monthly Process Narrative. The report will be reviewed by the Lead Evaluator at Wellington and Project Director at AHCCCS in order to identify any QI issues that need to be addressed with a focus on disparities in access/use/outcomes. In cases where an immediate response is needed, AHCCCS will contact the provider to address the issue. All other issues will be addressed as a standing agenda item on the monthly MAT-PDOA Criminal Justice Project meeting with the providers. As issues are identified, a Plan, Do, Study, and Act (PDSA) cycle (Plan: develop a plan; Do: try the plan on a small scale; Study: analyze the results; Act: refine and plan for the next cycle) will be implemented. The evaluator will assist in the implementation of PDSA to ensure data collection addresses the issue being tracked and assessed. The Monthly Process Narrative will also provide qualitative data on the following tracking of the QI process:

- a) How closely program implementation has matched the Plan/Changes made
- b) Change made to address disparities in access, service use, and outcomes across subpopulations
- c) Barriers to implementation and strategies to resolve
- d) Results of program monitoring visits

On a quarterly basis, project data will be analyzed and summarized in a report by the project evaluator. The quarterly report will include any progress at the program level. Data that reveals any sub-population disparities in access, retention, service utilization, or outcomes will be highlighted. The project director will work with providers and the project evaluator to develop plans to correct any disparities identified using the previously described continuous quality improvement process.

AHCCCS intends to use best practices to reduce disparities by using those treatments that are effective according to controlled research studies for individuals who are involved in the criminal justice system and require MAT services. Additionally, we will ensure the services are culturally competent care delivered in an effective, understandable and respectful manner, compatible with service recipients' preferred language and cultural beliefs.

**E3:** Wellington will develop a matrix for each data point in the local performance assessment to ensure that sufficient process and implementation information is being collected. The matrix will

include “responsibility” to identify the unit responsible for collecting the data. The project timeline provides an example of when local performance data will be collected. Wellington will develop a web portal for data collection. A web-based template for partners will also be used for monthly process updates on each major implementation measure. The number of new individuals outreached, number enrolled, number of continuing enrollees, total number of GPRAs administered, number of follow-ups and number of discharges, housing status, and mainstream services accessed will also be collected on a monthly basis on the web portal. This activity will alert the Project Team to gaps in the collection of performance data and enable a correction to be implemented. The providers will complete a Monthly Process Narrative Report to respond to the following questions each month.

1. Report on any updates to how program is organized (e.g., client flow: from outreach to aftercare, timing, services provided directly and through referral, type of services provided).
2. Report on any updates to integration of program with other services and systems (collaborations/partnerships and the structure of the collaboration/integration).
3. Report on any updates to number and type of evidence-based practices used to deliver the services – has anything occurred to impact the ability to practice the model? Any Adaptations and innovations? Any Changes within the context of local community?
4. Describe types of changes made to address disparities in access, service use, and outcomes across subpopulations.
5. Describe any changes in the program (i.e., activities or strategies not implemented and/or adapted, changes in intake / screening & assessment protocol, access and availability of services, changes in key program staff, and change in program resources).
6. Describe any challenges or barriers that have resulted in changes being made to original plan and Perception of impact of these changes on planned intervention.
7. Provide description of implementation protocols for outreach, treatment, housing, case management, and recovery support services strategies.

In addition to the process evaluation, the evaluator will finalize the outcome evaluation plan within two months of the project start date. The plan will include the following outcome questions: 1) What was the effect of the intervention on outcome goals/performance measures; 2) what program/contextual/cultural/linguistic factors were associated with outcomes; 3) what individual factors were associated with outcomes, including race/ethnicity/sexual orientation/gender identity; 4) how durable were the effects; and 5) Was the intervention effective in maintaining the project outcome at 6-month follow-up. Four sets of analyses will be used with the data to examine the relationships among participant demographics, program characteristics, and the desired outcomes: increased MAT admissions; increase in integrated care/treatment; decrease in illicit opioid drug use; and decrease in use of prescription opioids in non-prescribed manner. The first analysis will be a series of descriptive statistics, which will create a profile of the client participating in each program, including demographic variables. The second analysis will be a comparison of the difference in means scores between *intake* and *6-month follow-up* and *discharge*. These comparisons will employ ANOVA with Tukey post hoc analysis to examine the differences between time points both on single items and factor scales. The third analysis will be a comparison of key outcomes by demographic information (race/ethnicity/sexual orientation/gender identity). The fourth analysis will examine the standardized mean difference to estimate the effect of the MAT service on the specified GPRA

performance measures: abstinence from use, housing status, employment status, criminal justice system involvement, access to services, retention in services, and social connectedness.

**E4:** The Monthly Process reports will be reviewed by Project Director at AHCCCS, the Lead Evaluator, and program site administration and discussed during monthly project oversight meetings/phone call. The monthly GPRA reports will be reviewed by the Lead Evaluator to determine if performance measures and objectives are being met and whether issues have been raised that require further clarification or if there is a need to confer with AHCCCS to provide follow-up with a provider. As issues are identified, the Lead Evaluator will contact the specific provider for clarification and then determine whether a follow-up discussion of the issue needs to be brought to AHCCCS. The discussion issues will be put on the agenda for the monthly meetings. If the issue warrants immediate attention, an email is sent and the issue escalated to the appropriate person. When needed, an action plan will be put in place to address the issue and improve the project.

When a QI process is implemented, the evaluator will document the quality improvement strategies applied. In addition, strategies used by the MAT-PDOA Criminal Justice Project will be examined to assist in the overall quality improvement of the system of care for individuals who are involved in the criminal justice system requiring MAT services.

#### **Section F: States Identified in Section V (10 points)**

**F1:** According to ADHS/DBHS Treatment Episode Data Set information collected, from 2007 to 2013 Arizona has had a 116% increase in Primary Treatment Admissions for Heroin and a 238.1% increase in Primary Treatment Admissions for Non-Heroin Opiates. See table in Attachment 5 for full details.